

**BOSTON INSPECTIONAL SERVICES DEPARTMENT
DIVISION OF HEALTH INSPECTIONS
1010 MASSACHUSETTS AVENUE
BOSTON, MA 02118
(617) 635-5326
Fax (617) 635-5388**

2001 APPLICATION FOR RECREATIONAL CAMP LICENSE

DATE _____

NAME OF CAMP _____ PHONE # _____

ADDRESS _____ CITY/TOWN _____ ZIP _____

CAMP OWNER _____

WINTER ADDRESS _____ CITY/TOWN _____

ZIP _____ WINTER PHONE # _____

CAMP DIRECTOR _____

TYPE OF CAMP: Residential (Operates 24 hours) _____ Day (Operates less than 24 hours) _____

If you have any **special needs campers** please note the needs: _____

Do you anticipate any overnights? Yes _____ No _____ Where? _____

Length of camp season: _____ to _____ Hours _____ A.M. _____ P.M.
(start) (finish)

Number of sessions per season: _____

Camp Capacity Per Session: _____ No. of Staff Persons: _____
(Max # of Campers) (Supervising Campers)

Building Capacity: _____

Cert. of Inspection/Bldg. Div. **Certificate No.** _____ **Expires** _____

Fire Dept. Inspection **Permit No.** _____ **Expires** _____

What type of fire alarm, detector, or fire fighting equipment is present?

Has the camp owner or director obtained and reviewed the CORI and * SORI of each staff person who may have contact with a camper? Yes _____ No _____ (*SORI -ONLY IF NOT IN ABEYANCE)

FOOD SERVICE:

Is food handled, served or prepared? Yes _____ No _____

To what extent?

Snacks _____ Cooked and served by staff _____ Catered _____ If so, by whom? _____

Is refrigeration available for perishable foods? Yes _____ No _____

(OVER)

SWIMMING AREA:

Do you have or use a bathing area? Fresh water _____ Ocean _____ Pool _____ None _____

If yes, location of beach _____

If yes, location of pool _____

Who is the **Aquatics Director** responsible for the supervision of the pool or swimming area?

Qualifications of Aquatics Director:

Water Safety instructor or equivalent Yes _____ No _____

CPR Training Yes _____ No _____

First Aid Training Yes _____ No _____

Name(s) of other lifeguards and credentials: _____

Does the camp participate in any watercraft/boating activities? Yes _____ No _____

WATER SUPPLY: Public _____ Private _____

If private, date sampled _____ By whom? _____

Results _____

SEWAGE DISPOSAL: Public _____ Private _____ (please specify) _____

TOILET/SHOWER ROOMS: Number of toiletsfor males _____ for females _____

Handwash basinsfor males _____ for females _____

Showersfor males _____ for females _____

MEDICAL CARE: Who is responsible **at the camp** for medical care or first aid?

Name of Physician (Health Care Consultant) “on call”: _____

Address _____ Phone No. _____

Name and address of **hospital** used for emergency services: _____

Name of Health Care Supervisor: _____

Does the camp have or contract with any transportation vehicles? Yes _____ No _____

Have you verified that the driver is properly licensed and meets required qualifications? Yes _____ No _____

When will the camp be ready for inspection? _____

(DATE)

Signed: _____

Date: _____